# Capability Development Guide for Employees

## How to use this guide

### What's the purpose of this guide?

This guide is designed to help you plan the development activities that will help you to build the Healthcare Quality and Safety Capabilities.

When considering how to develop in each of the capability areas, use this guide for ideas. The ideas following the 70-20-10 rule to development.
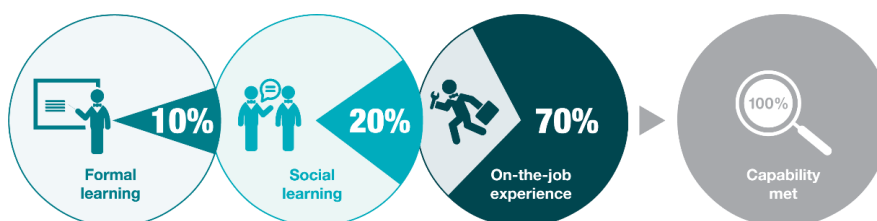
### What is 70-20-10?

The 70-20-10 learning design is a learning approach where 70% of learning comes from on the job or action learning; 20% comes from relational-based activities and 10% comes from formal training events.

Research in adult learning has indicated that the 70/20/10 model of development is central to knowledge and skill development. This is because the use of multiple methods can assist capability to grow over time.

When writing capability development plans, staff and managers should discuss:

- **70%:** What can be done through learning via practise, critical reflection and feedback? What challenging assignments can be undertaken? Where can the staff member get exposure to building capability?

- **20%:** What developmental relationships can the staff member engage in, such as a mentor? What can be done through learning from another experienced individual (e.g. shadowing, coaching, observing and asking questions)?

- **10%:** What requires formal training?

When writing the capability development plan, first identify what can be learned on the job and from peer-to-peer learning. This does not mean you are required to seek out opportunities only within your organisation. You have the whole of NSW Health to consider. Only seek out formal training, when the expertise needed for employee development exists beyond networks or there is a compelling reason to support team and organisational objectives.



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|---|---|---|---|
| 10% Formal learning | 20% Social learning | 70% On-the-job experience | 100% Capability met |

# Capability: Contribute to High Reliability

**Understand and apply knowledge regarding how the organisational, team and individual conditions influence reliable service delivery to achieve safe, high-quality care**

## Foundational

- Use the of Safety Fundamentals for Teams, or local equivalent
- Employ techniques to communicate safety concerns assertively, e.g. PACE or CUSS in clinical settings
- Employ techniques to share information and transfer knowledge that ensures the communicator knows they have been heard and understood, e.g. ISBAR in clinical settings
- Be aware of safety and quality data sources and where to access them
- Read and interpret charts used to display safety and quality data

## Intermediate

- Understand the characteristics of high-reliability organisations and how they apply in healthcare organisations
- Lead the use of Safety Fundamentals for Teams, or local equivalent
- Lead the use of communication tools and techniques to acknowledge others' safety concerns and to share information and transfer knowledge
- Use safety and quality data to inform decision-making to deliver reliable care

## Adept

- Understand the concepts:
    - The elements of a safety culture
    - Safety I and Safety II
    - Work-as-imagined versus work-as-done
    - Efficiency-thoroughness trade-off
    - Hierarchy of Intervention Effectiveness
- Build teams with effective communication, psychological safety to raise concerns and ask questions, and demonstration of respectful behaviour
- Discuss the interaction of safety and efficiency with team members to identify risk and ensure reliability of service delivery
- Embed the use of Safety Fundamentals for Teams, or local equivalent in your unit or service
- Monitor and use safety and quality data over time to ensure reliable service delivery in your unit or service

# Capability: Contribute to High Reliability

**Understand and apply knowledge regarding how the organisational, team and individual conditions influence reliable service delivery to achieve safe, high-quality care**

## Advanced

- Apply Human Factors' principles, tools, and methodologies in the design and evaluation of interventions, technologies or processes in the organisation
- Provide expert guidance on how to build effective teams that understand the influence of human factors at work
- Use simulation resources for improvement work and education
- Lead organisation-wide discussions about the interaction between safety and efficiency to educate leaders about risk to reliability of service delivery
- Implement safety and quality data systems to support the organisation to reliably deliver care

## Highly Advanced

- Collaborate with the Senior Executive to invest in expertise and staff capability in Human Factors' principles, tools, and methodologies, and their utility in healthcare design and service delivery
- Promote the use of simulation resources for improvement work and education to clinical leaders
- Provide expert guidance on the tension that efficiency and service delivery pressures have on safety and quality outcomes for staff and consumers
- Provide expert guidance on how to use data systems to support the organisation to safely and reliably deliver care

# Capability: Manage Clinical Incidents and Risk

**Identify, communicate and manage clinical incidents and risk**

## Foundational

- Follow NSW Health patient safety policies and practices
- Take responsibility for error and harm and communicate where appropriate
- Identify and notify incidents, near- misses and environmental hazards
- Participate in team learning activities about incidents, near-misses and environmental hazards
- Escalate incidents, near-misses and environmental hazards to the appropriate manager

## Intermediate

- Support your unit or service to monitor requirements regarding the organisation's safety and quality accreditation process and other safety assurance activities
- Participate in unit or service-level incident reviews
- Complete clinical risk and environmental hazard analyses requested of work environment in a professional manner

## Adept

- Explain the legislation and regulatory processes and policies relevant to incident reviews and clinical risk management to the team
- Lead unit or service-level incident reviews
- Monitor and meet requirements regarding the organisation's safety and quality accreditation process and other safety assurance activities
- Track unit or service-level clinical risk and environmental hazard analyses and recommendations

# Capability: Manage Clinical Incidents and Risk

## Identify, communicate and manage clinical incidents and risk

### Advanced

- Understand patient safety concepts and incident review and clinical risk methodologies
- Monitor and disseminate information on legislation and regulatory processes and policies relevant to patient safety
- Establish appropriate teams to lead incident reviews
- Generate and monitor recommendations for clinical risk and environmental hazard management strategies
- Understand clinical risk management and its relationship to enterprise-wide risk management, and apply this to operational planning

### Highly Advanced

- Act as primary source of expertise in patient safety concepts and incident review methodologies
- Ensure the organisation upholds all legislation and regulatory processes and policies relevant to incident reviews and clinical risk management
- Lead the organisation's compliance with its relevant safety and quality accreditation process and other safety assurance activities
- Provide expert guidance to teams completing incident reviews and clinical risk and environmental hazard analyses
- Incorporate clinical risk management into strategic and operational planning

# Capability: Manage Individual Factors that Influence Performance at Work

**Be aware of thoughts, emotions and physical feelings that influence effective performance at work and adapt when necessary to deliver safe, reliable care**

## Foundational

- Be able to recognise and name own emotions and physical feelings
- Be able to recognise and name emotions and physical feelings displayed by others
- Understand that emotions can have a positive and negative impact on work performance and relationships
- Self-assess if you are fit for work and communicate this to your direct supervisor

## Intermediate

- Monitor own emotions and physical feelings, and adapt to ensure they do not negatively impact on work performance and relationships
- Identify other people's emotions and physical feelings to understand their perspectives
- Understand what a cognitive bias is and how it influences decision-making
- Assess other staff's fitness for work and care for them to prevent negative outcomes

## Adept

- Practise self-reflection and emotional regulation, and understand the impact of own and others' emotions and physical feelings on safety
- Critically reflect on own cognitive biases and how they influence decisions, behaviours and actions at work
- Role-model reflective practice by leading discussions about learning for improvement
- Lead open discussions about how team members' emotions and physical feelings impact safety

# Capability: Manage Individual Factors that Influence Performance at Work

**Be aware of thoughts, emotions and physical feelings that influence effective performance at work and adapt when necessary to deliver safe, reliable care**

## Advanced

- Assist leaders to develop their Emotional Intelligence capability to be effective safety and quality leaders
- Provide expert guidance on how to reduce cognitive biases' influence on leadership practice
- Provide expert guidance on how to use critical reflection skills for learning for improvement
- Review and improve organisational policies, procedures and guidelines to consider human factors

## Highly Advanced

- Role-model own Emotional Intelligence capability to set the expectation that it is an essential safety leadership behaviour
- Lead the organisation to protect time for staff to engage in reflective practice for learning for improvement
- Ensure human factors are considered in organisational policies, procedures and guidelines

# Capability: Uphold a Safety Culture

**Support staff, patients, families, and carers to feel safe, engage in learning and to acknowledge when an incident has occurred**

## Foundational

- Contribute to a safety culture by asking questions, sharing ideas and concerns, and reporting incidents
- Actively learn from mistakes, rather than assign blame
- Provide authentic support to patients, families, carers, or other staff after an incident
- Seek to understand what matters most to patients, families, carers, and customers and what drives complaints
- Acknowledge the physical and psychological needs of staff involved in incidents
- Undertake clinician disclosure or relevant disclosure process in collaboration with the health entity partner, including an apology, within 24 hours of an incident

## Intermediate

- Role-model psychological safety in your unit or service by speaking up when there is a safety concern
- Assist less experienced team members to provide authentic support to patients, families, carers, or other staff after an incident
- Participate in Open Disclosure following incidents
- Assist less experienced team members to discuss what matters most with patients, families, carers, and customers and what drives complaints
- Offer physical and/or psychological wellbeing support to staff involved in incidents

## Adept

- Recognise and reward staff for speaking up about safety and supporting others to do the same
- Lead reviews following incidents and near-misses in a calm, logical and reflective manner so that others feel psychologically safe to contribute
- Ensure there is authentic and appropriate support provided to patients, families, carers, or other staff after an incident
- Ensure staff in your unit or service understand and participate in the Open Disclosure process
- Set the expectation in the unit or service that understanding consumer or customer needs and complaints are essential for high-quality, reliable service delivery
- Lead open discussions on how to support each other when involved in incidents and where to access organisational physical and psychological wellbeing resources
- Follow up with staff who have been involved in incidents regarding ongoing need for support

# Capability: Uphold a Safety Culture

**Support staff, patients, families, and carers to feel safe, engage in learning and to acknowledge when an incident has occurred**

## Advanced

- Recognise and reward units and services for engaging in learning practices, speaking up when there is a safety concern, and reporting and reviewing their incidents
- Provide expert guidance on how to create an environment in the incident review that encourages learning, openness, transparency, and accountability so that others feel psychologically safe to contribute
- Ensure no blame is placed on staff in incident reviews without proof of negligence of the offense
- Design and implement systems, processes and resources that support a staff safety culture, and that support patients, families and carers who have been involved in incidents

## Highly Advanced

- Collaborate with the Senior Executive to ensure there are resources and processes to drive a culture of psychological safety and learning from a range of data sources
- Safeguard the incident review process from blame by influencing the Senior Executive to commit resources to develop an environment that supports learning, openness, transparency, and accountability
- Ensure there are organisational resources and processes available for staff psychological and physical wellbeing immediately and ongoing after an incident
- Provide expert guidance on how to authentically restore trust between the health organisation and patients, families and carers who have been involved in incidents

# Capability: Utilise Improvement Methodologies

**Able to understand and utilise appropriate improvement, research and applied science methodologies to achieve change for healthcare improvement**

## Foundational

- Be aware of the concepts of quality improvement in healthcare
- Know where to find more information about the improvement resources available within the organisation
- Think about different possibilities as to how service delivery works
- Approach testing changes to service delivery from the perspective of making things better and safer
- Be confident to offer ideas on service delivery improvement
- Take responsibility for raising and fixing issues encountered at work
- Understand a range of improvement data that exists in healthcare

## Intermediate

- Use knowledge, skills and experience that you have gained from other contexts to inform new ideas for service delivery improvement
- Test ideas to demonstrate their worth for making things better and safer
- Be confident to push boundaries and take measured risks when appropriate to improve service delivery
- Understand what constitutes good aims and measures in improvement initiatives
- Understand risk to improvement initiatives
- Collect and analyse data to inform improvement conversations and initiatives
- Be able and willing to participate in an improvement project that is underpinned by improvement methodologies
- Recognise the importance of 'spread' of quality improvement initiatives and participate in this process

# Capability: Utilise Improvement Methodologies

**Able to understand and utilise appropriate improvement, research and applied science methodologies to achieve change for healthcare improvement**

## Adept

- Apply quality improvement methods and tools to suit the context of the improvement needed
- Understand the need for appropriate diversity in quality improvement teams
- Provide guidance on quality improvement to others in your unit or service
- Understand the importance of a Family of Measures for improvement initiatives
- Read and interpret data presented in quality improvement tools/systems
- Understand benchmarking, common cause variation and special cause variation as it applies to quality improvement work
- Understand and apply the principles of Human-Centred Design
- Support challenging conversations about change ideas with teams
- Help to remove barriers to change for improvement
- Critique improvement work as it relates to the organisation's strategic and operational plans and outcomes
- Understand and apply evidence-based change management methods for service delivery improvement
- Support spread of quality improvement initiatives

# Capability: Utilise Improvement Methodologies

**Able to understand and utilise appropriate improvement, research and applied science methodologies to achieve change for healthcare improvement**

## Advanced

- Provide expert guidance about improvement methodologies and tools
- Understand and interpret variation in data and how it relates to quality improvement
- Provide expert guidance on benchmarking, common cause variation and special cause variation to improvement project leaders
- Use data to understand if improvement is being achieved and to identify where opportunities for improvement exist
- Teach others how to use Human-Centred Design
- Support units and services to think creatively and innovatively about improvement and role-model creative and innovative thinking in your leadership practice
- Provide resources to support creativity and innovation in units and services
- Facilitate productive discussions about organisational change for improvement
- Create networks to enable spread of improvement work that achieves safety and quality organisational objectives

## Highly Advanced

- Provide expert guidance on what a continuous improvement culture looks like
- Provide expert guidance about data for improvement and how to use it to achieve strategic objectives
- Champion the use of data systems to inform quality improvement work
- Provide expert guidance on why it is critical to protect time for staff to actively engage in thinking creatively and innovatively about service delivery improvement
- Collaborate with the Senior Executive to remove organisational barriers that prevent creative and innovative thinking
- Collaborate with the Senior Executive to invest resources and time into testing new ideas for improvement
- Endorse ideas that are creative and innovative at the highest organisational level, that are also underpinned by sound evidence, measurement and evaluation
- Use change management strategies expertly to lead organisational change for safety and quality

# Capability: Utilise System Thinking

**Able to see the individual parts of the healthcare organisation, how they operate and interact, and their patterns of behaviour over time, and to use that information to contribute to change for safety and quality**

## Foundational

- Understand the unit's and service's purpose, design and models of care
- Understand how taking action to improve service delivery might impact patients, families, carers, and staff in your or other units or services
- Recognise your role in a patient's journey and how your actions can affect patient experience in other units and services
- Recognise your role in the unit or service and how your actions can affect other staff and leaders' ability to deliver services
- Understand your role in the patient journey and how your role affects the patient's overall health outcomes
- Enter information into data systems for reference along the patient journey

## Intermediate

- Anticipate the impacts of interactions between staff, teams, consumers and customers in your unit or service
- Cultivate and maintain a network of relationships outside your unit, within the service or District/Network, which you can use to achieve safety and quality improvement outcomes
- Connect patients, families, carers, or other staff and leaders with the support they need from other units or services where you work
- Follow up with patients, families, carers, or other staff and leaders to see if they received the support they needed from other units or services where you work
- Use all information from data systems to provide safe and efficient care

# Capability: Utilise System Thinking

**Able to see the individual parts of the healthcare organisation, how they operate and interact, and their patterns of behaviour over time, and to use that information to contribute to change for safety and quality**

**Adept**

- Determine and articulate approaches to achieve goals that consider:
    - Ambiguities
    - Obstacles,
    - Changing circumstances
    - Consequences in the service of District/Network
- Utilise your network of relationships to understand the parts of the healthcare system and how it operates holistically to achieve safety and quality outcomes for your service and District/Network
- Identify patient safety or work, health and safety practices that might impact innovative ideas for improvement and vice versa
- Interpret when innovative ideas for improvement may pose new risks or introduce new harms
- Understand and use analysis tools to learn about the contributing factors to how events occur in a complex system
- Ensure your unit or service contributes to and references accurate and timely information

# Capability: Utilise System Thinking

**Able to see the individual parts of the healthcare organisation, how they operate and interact, and their patterns of behaviour over time, and to use that information to contribute to change for safety and quality**

## Advanced

- Build decision networks and navigate politics to achieve outcomes that account for
  - Ambiguities
  - Obstacles
  - Changing circumstances
  - Consequences in the service or District/Network
- Educate leaders about the parts of the healthcare system and how it operates holistically
- Educate leaders about how to interpret when innovative ideas for improvement may pose new risks or introduce new harms
- Provide expert guidance on how to use analysis tools to learn about the contributing factors to how events occur in a complex system
- Ensure data systems are used to analyse information to contribute to improved patient outcomes and experience across the patient journey

## Highly Advanced

- Be able to consider situations, challenges or ideas regarding safety and quality in the widest context relevant to NSW Health
- Provide expert guidance on the parts of the healthcare system and how it operates holistically, as well as how to change the system to deliver safe, reliable care
- Provide expert guidance on the variety of analysis tools available to your organisation that support services to learn about the contributing factors to how events occur in a complex system
- Provide expert guidance on the use of data systems to ensure a safe and efficient patient journey